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ABSTRACT

This publication includes five articles on health care and health promotion within impoverished communities. "The Health of Families and Communities" (Douglas W. Nelson) introduces the issue, discussing the work of the Annie E. Casey Foundation in communities. "Inconspicuous Consumption: Treating Latent TB Infection in Seattle" (Bill Rust) reports on an effective pilot program to help refugees in Seattle successfully complete a 6-month program of therapy for latent tuberculosis infection. "Health Care for All: Medicaid and CHIP Outreach in New Orleans" (Michael DeCourcy Hinds) describes a neighborhood-based program to sign up more children who are eligible for public health insurance. "The Capacity to Heal: The Rebirth of a Community Health Center in Richmond" (Bill Rust) tells the story of a community-wide effort to reopen a defunct neighborhood health center. "Walking the Plain Talk: Protecting Sexually Active Teens in Atlanta, New Orleans, and San Diego" (Bill Rust) assesses the Annie E. Casey Foundation's community-based initiative to protect sexually active teens from pregnancy and sexually transmitted diseases. (SM)

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DOCUMENTING PROGRAMS THAT WORK FOR KIDS AND FAMILIES

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THE REBIRTH OF A COMMUNITY HEALTH CENTER IN RICHMOND

WALKING THE PLAIN TALK

PROTECTING SEXUALLY ACTIVE TEENS IN ATLANTA, NEW ORLEANS, AND SAN DIEGO

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THE HEALTH OF FAMILIES AND COMMUNITIES

BY DOUGLAS W. NELSON

Good health is a key determinant of the economic security of families, the educational achievement of children, and the overall strength and resilience of communities. Among other things, good health enables parents to work and care for their children, and it allows children to attend school and develop their full potential.

In low-income neighborhoods, the barriers to good health are formidable. In contrast to affluent communities, working families in poor neighborhoods are far less likely to have adequate health insurance, which in turn means less treatment for sickness and injury, less frequent well-child visits and other preventive services, and more reliance on high-cost emergency room care. Mothers who lack health insurance are less likely to seek prenatal care and more likely to give birth to low-birthweight babies.

Poor communities also often have less accessible medical and public health services, which contribute to higher rates of tuberculosis, asthma, and other chronic illnesses. In such neighborhoods, good health outcomes are further jeopardized by environmental hazards — for example, lead contamination in deteriorating housing. And in places where family stresses are compounded by poverty, violence, and drugs, adolescents are at a much higher risk of creating a pregnancy and getting sexually transmitted diseases.

Recent sweeping changes in this nation's health care system have done little to alleviate (and have sometimes exacerbated) the health disadvantages of low-income communities. Medical decisions, which used to be made by patients with their physicians alone, now increasingly involve a third party — typically some form of managed care organization. Yet many managed care providers do not offer an appropriate level of care for low-income families, especially those with multiple health care needs. Moreover, hospital closures, mergers, and other cost-cutting measures have actually reduced medical care in many of our highest need communities.

Community Connections

The Annie E. Casey Foundation's work in health is grounded in the conviction that all families should have access to quality health care. Such care should include core medical, dental, and mental health services and should emphasize prevention and primary care. Moreover, health care systems, as much as is practical, should serve families in their own neighborhoods.

Among the array of public and private organizations addressing child and family health, the Casey Foundation focuses on two strategies that reflect our approach to helping transform tough neighborhoods into environments that support families. One is increasing the capacity of low-income communities to identify health problems, define appropriate services, and assess their quality. The other is helping health systems and other external resources connect more effectively with high-need, underserved neighborhoods.

The four reports in this issue of ADVOCASEY illustrate aspects of our approach to better health care in low-income communities. "Health Care for All" describes a promising neighborhood-based program to sign up more of the children who are eligible for public health insurance. Operating in a housing development in New Orleans, the program is an active, door-to-door campaign that uses community residents to help families navigate the complexity and confusion surrounding the State Children's Health Insurance Program and Medicaid.

But insurance coverage, in and of itself, does not guarantee good health outcomes. Access to quality health care is critical. "The Capacity to Heal" is the story of a community-wide effort to reopen a defunct

neighborhood health center in the East End of Richmond. A local governing board established by the Foundation's Mental Health Initiative for Urban Children played a leading role in the effort, and a group of unemployed fathers with trade skills renovated the clinic. The result was the creation of a major health resource in a medically underserved area.

The factors that promote or impair health are not only biomedical, but also cultural, economic, and environmental. "Inconspicuous Consumption" reports on an effective pilot program to help refugees in Seattle successfully complete a six-month program of therapy for latent tuberculosis infection. Outreach workers from diverse refugee communities are the key to the project, helping fellow immigrants overcome misunderstandings and mistrust related to TB and health care in the United States. The program has been responsible for dramatic increases in the proportion of refugees who successfully complete preventive TB therapy.

"Walking the Plain Talk" assesses the Casey Foundation's community-based initiative to protect sexually active teens from pregnancy and sexually transmitted diseases. The article focuses on three neighborhoods in Atlanta, New Orleans, and San Diego, where there was extensive ethnographic and outcomes research on the impact of Plain Talk. Independent evaluators from Public/Private Ventures found strong links between improved adult-youth communication and reductions in pregnancy and STDs.

Many themes emerge from these four stories, but three stand out. One is that leadership from credible community organizations is a key element of planning and delivering services in tough neighborhoods. Another is that when health care providers and systems listen — both to patients and to communities — the results are better health outcomes. And third, as with other social services, community-planned and community-managed approaches to health care not only work better for patients, but also contribute jobs and economic development to neighborhoods that need them most.

As always, my colleagues and I welcome your comments and questions about our work.

Douglas W. Nelson is the president of the Annie E. Casey Foundation.

DOCUMENTING PROGRAMS
THAT WORK FOR KIDS AND FAMILIES

ADVOCASEY

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The Annie E. Casey Foundation is a private charitable organization dedicated to helping build better futures for disadvantaged children in the United States. The primary mission of the Foundation is to foster public policies, human-service reforms, and community supports that more effectively meet the needs of today's vulnerable children and families. In pursuit of this goal, the Foundation makes grants that help states, cities, and neighborhoods fashion more innovative, cost-effective responses to these needs.

The Annie E. Casey Foundation was established in 1948 by Jim Casey, one of the founders of United Parcel Service, and his siblings, who named the Foundation in honor of their mother.

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INCONSPICUOUS CONSUMPTION

TREATING LATENT TB INFECTION IN SEATTLE

BY BILL RUST

The tuberculosis hospitals and sanatoria in the United States have been shut down for 30 years or more. Although still a serious public health threat, TB disease has been curable since the development of effective antibiotics, which are widely available in industrialized nations. Tuberculosis can also be prevented in people who inhale the bacterium that causes the disease and develop latent TB infection. People with this infection have no symptoms and cannot spread the disease. They are, however, at risk of developing active, contagious TB disease at some time in the future.

A lump on the arm from a skin test indicates that latent TB infection is likely. After ruling out the presence of active tuberculosis through a chest x-ray and perhaps other tests, health care workers must determine whether a patient is at high risk of developing TB disease. Although 90 percent of people with latent tuberculosis infection do not develop TB disease, those who have recently been exposed to the disease or have weak immune systems are especially vulnerable. For these patients, a six- or nine-month regimen of daily oral medication is prescribed. When taken as directed, the medication is highly effective.

From a biomedical and public health perspective, the approach to latent TB infection summarized above is relatively straightforward, reliable, and safe. Yet from the point of view of an immigrant from Southeast Asia, Eastern Africa, or another part of the world where TB is still a leading cause of death, this way of diagnosing and treating tuberculosis infection often seems nonsensical or worse. For example, in Somalia, where there is insufficient health care financing to detect and treat active TB disease cases, much less latent TB infections, the concept of preventive health care simply does not exist. Tuberculosis means a sick person with a persistent cough, fever, and weight loss, not someone who feels fine and has a normal chest x-ray.

A serious consequence of this and other cultural misunderstandings about tuberculosis is that many immigrants do not complete the recommended treatment for latent TB infection. Getting anyone without symptoms to take drugs daily for six months or more is a well-known medical challenge. If the patient is an immigrant from a country like Bosnia, where herbal medicines are preferred, and pharmaceuticals, or "chemical medication" as they are called, are viewed with suspicion, the challenge is that much greater.

Some immigrants' reluctance to begin or complete preventive TB therapy is reinforced by the stigma associated with the disease in many parts of the world. Depending on the country, tuberculosis might be viewed as a punishment or test from God. The diagnosis of the disease can mean exclusion from meals, homes, and work, which is often emotionally devastating for the outcast. "The threshold for admitting that you have tuberculosis is extremely high," says Dr. Carey Jackson, director of the International Medicine Clinic at Harborview Medical Center in Seattle. "You would have to be hacking up blood, losing weight, and even then you might try to say you have cancer or something else."

Carey Jackson is a medical anthropologist and the principal investigator for a program designed to demonstrate an effective way of helping newcomers successfully complete treatment for latent TB infection. Jointly operated by the International Medicine Clinic and the Seattle–King County Tuberculosis Control Program, the project trains members of specific refugee communities as outreach workers who help newcomers overcome misunderstandings and mistrust related to TB and health care in the United States.

The Refugee TB Prevention Program also includes focus groups aimed at helping health care workers better understand immigrants' perceptions of health, illness, and tuberculosis. "We need to listen to our patients, rather than just talk at them and tell them what their problem is and what they need to do," says Dr. Charles Nolan, director of the Tuberculosis Control Program in Seattle and King County. "We need to hear how they interpret what we're telling them. We need to hear how they understand TB and health in general. And we'll use a mutual understanding as a basis for giving what we think is good sound advice."

Funded by a federal refugee program, the Annie E. Casey Foundation, and the Firland Foundation, a Seattle philanthropy that focuses on tuberculosis and chronic respiratory diseases, the Refugee TB Prevention Program has had very encouraging preliminary results. According to a new report from the Institute of Medicine (IOM), which was established by the National Academy of Sciences to examine public health issues, the program's 88 percent rate for patients completing preventive therapy "far exceeds the 60–70 percent completion rates obtained by routine programs, and this success has been obtained with a population that is considered to be particularly difficult to complete treatment for latent infection."[1]

cuts in funding for tuberculosis control in the 1960s and '70s, combined with "a laissez-faire attitude toward treatment of the disease," helped set the stage for TB's dangerous and costly resurgence in the late 1980s and early 1990s.

A key finding of the IOM report is that immigrants from countries with high rates of tuberculosis are an increasing proportion of the TB cases in the United States. The newcomers' period of greatest risk for developing the disease is during their first five years in the country. "Forty percent of the active TB in this country is foreign born, and the percentage is growing every year," says Dr. Patrick Chaulk, a senior associate at the Annie E. Casey Foundation and a member of the IOM committee that produced the study. "The challenge for the public health community is to figure out a way to effectively serve high-risk immigrant communities."

In Seattle and King County, where the rate of 6.2 tuberculosis cases for every 100,000 people is about the same as the national rate for TB cases, the most important risk factor for having the disease is place of birth. "Our primary high-risk group is persons who have recently immigrated from parts of the world where TB is highly endemic," says TB control director Nolan. "About seven out of ten of our cases of TB arise from that population."

For immigrants from parts of the world where TB is still a leading cause of death, the U.S. way of diagnosing and treating tuberculosis infection often seems nonsensical or worse.

"Miserable" Results

Released in May, the comprehensive IOM study reports that tuberculosis in the United States is "at an all-time low in the number of new cases." The report warns, however, that this success poses another risk: complacency in the fight to eliminate TB. According to the authors of the study, which was sponsored by the Centers for Disease Control and Prevention,

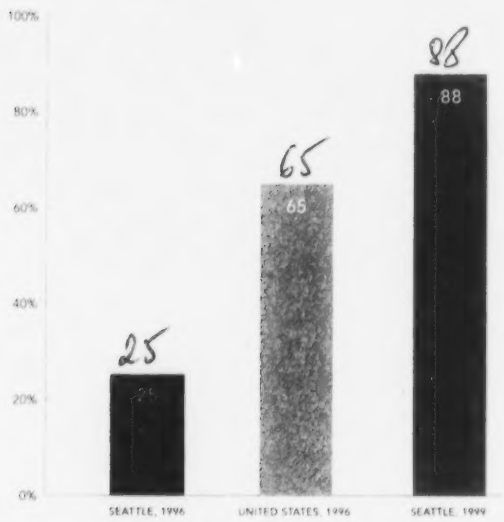
In recent decades, the Seattle area has been a safe haven for immigrants fleeing international trouble spots. In the 1970s, Seattle initially attracted refugees from the conflicts in Southeast Asia. More recently, the area's immigrants have come from Somalia, the Balkans, and republics in the former Soviet Union. One consequence of the civil strife and poverty in these regions has been high rates of tuberculosis. In Somalia, about 50 percent of the population has latent TB infection, a figure that is ten times the U.S. rate. And according to the World Health Organization, serious new outbreaks of tuberculosis "have occurred in Eastern Europe, where TB deaths are increasing after almost 40 years of steady decline."

[1] *Ending Neglect: The Elimination of Tuberculosis in the United States*, Institute of Medicine, National Academy Press, Washington, D.C.

BY THE NUMBERS

COMPLETING PREVENTIVE TB THERAPY

In 1996 only 25 percent of the foreign-born people in Seattle and King County who needed preventive therapy for TB completed the six-month program of treatment. By comparison, nationwide completion rates that same year were 65 percent. After the establishment of the Refugee TB Prevention Program, completion rates for preventive TB therapy in Seattle and King County increased to nearly 90 percent.



Sources: TB Control Program, Public Health – Seattle & King County; Centers for Disease Control and Prevention

In Seattle, the specific TB control problem facing Nolan and his colleagues was that among the newcomers who received recommendations for preventive treatment, only about 50 percent began taking medication. And of the people who started the six-month treatment, only about half completed it, typically quitting therapy after only a few weeks. In other words, only one-quarter of this group of people who needed the treatment successfully completed it. Characterizing these results as "miserable," Nolan and others questioned whether scarce public resources should be devoted "to such an ineffective program."

"Why Are You Making Such a Fuss?"

To address this problem of "compliance," Seattle's TB control officials became increasingly interested in the views of Carey Jackson, who in addition to directing the International Medicine Clinic was the codirector of Community House Calls. A comprehensive health and social services outreach program, Community House Calls uses bilingual case managers to learn about the needs and strengths of refugee families and to help provide appropriate services. For this work, Jackson received a 1999 Community Health Leadership Award from the Robert Wood Johnson Foundation.

Jackson concluded that poor compliance among immigrants was rooted in misunderstandings about tuberculosis and mistrust of the U.S. health care system. One area of confusion is the tuberculin skin test. In many parts of the world, but not the United States, a vaccination called BCG is used to reduce the likelihood and severity of tuberculosis disease in children. Limited in its effectiveness, BCG sometimes causes a "false positive" tuberculin skin test. Given the stigma and misery associated with TB in their homelands, some immigrants are eager to embrace the interpretation of their native health care system that a prior BCG vaccination — not latent TB infection — is the reason for the positive skin test. Others assume that U.S. health care workers "'don't understand how things operate in my country,'" says Jackson.

Another source of misunderstanding is the medication for treating latent TB infection, isoniazid. Commonly called INH, isoniazid has been shown to have an effectiveness rate of up to 90 percent when taken as directed. Although the side effects of INH include the risk of liver disease, careful monitoring of patients can reduce this possibility to a very low level. A seven-year study examining INH's impact on the liver, conducted at the Seattle–King County Public Health Tuberculosis Clinic, found that only 11 patients out of more than 11,000 (or 0.1 percent) developed hepatitis. There were no deaths, and only one patient was hospitalized.

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Such findings, however, offer little comfort to emotionally and immunologically stressed refugees who have been told by their countrymen that INH damages the liver. Mohamed Jama, a Somalian outreach worker for the Refugee TB Prevention Program, reports a typical fear of new refugees from his country: "We heard that in America they do a lot of experimental medication. Are they going to experiment with us?"

Although new immigrants may not know a great deal about U.S. biomedical practice and public health concerns, many are aware that decisions about treatment for preventing TB disease are based on statistical probability rather than individual circumstances. From the perspective of refugees — who already are facing numerous adjustment issues including shelter, employment, and schools — it appears they are being singled out for treatment. "'Why are you guys making such a fuss?'" says Carey Jackson, summarizing the immigrants' point of view. "'It must be because we're second-class citizens, and you need to look closely at us.'"

Of course, misunderstandings are not limited to newcomers. In the United States, where death from TB is rare, health care workers often do not appreciate the fear and stigma some immigrant patients associate with tuberculosis. In many countries, TB is quite simply the worst disease one can have.

To illustrate this point, Jackson tells the story of a 73-year-old Chinese woman who was relieved to find out that she had untreatable lung cancer instead of TB. Although grief-stricken that she had a terminal illness, the woman explained that a diagnosis of TB would have meant that she would be unable to spend the remaining months of her life holding her grandchildren and cooking for them. Moreover, infecting her grandchildren with her cough was, in Jackson's words, "the worst possible scenario."

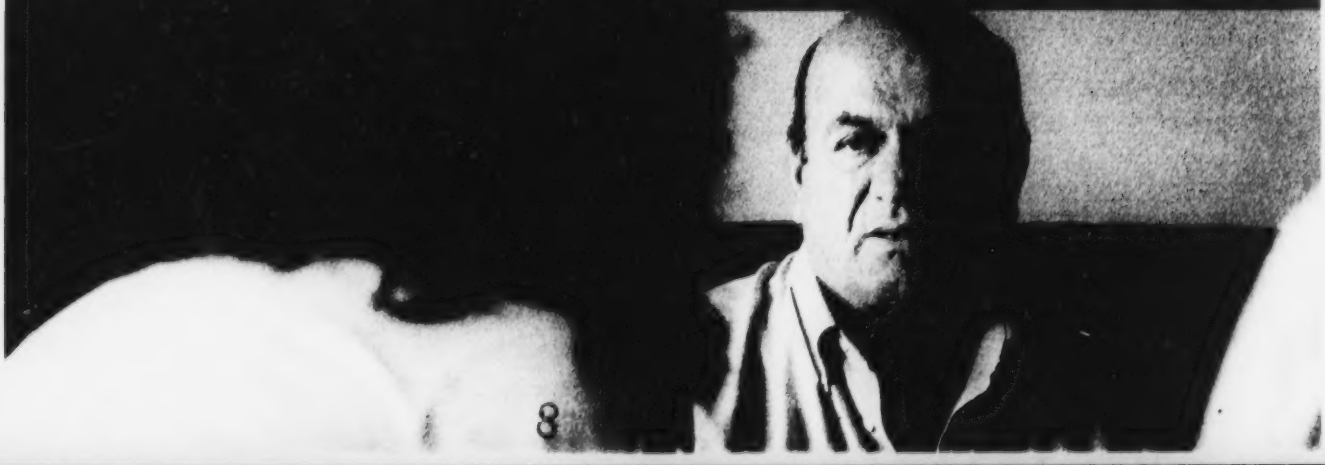
"Credibility in the Community"

By all accounts, a key reason for the success of the Refugee TB Prevention Program has been its outreach workers, who are also called "peer health advisers." Members of the immigrant communities they serve — Somali, Bosnian, and Ukranian and Russian — the outreach workers must not only be bilingual, but also trusted by the refugees. When recruiting prospective outreach workers, the project values experience in working with fellow immigrants over any medical training. "If you use a health outreach worker from the community you're dealing with," says Charles Nolan, "it automatically gives you much more credibility in that community."

The outreach workers receive about four weeks of basic clinical training about TB — for example, its signs and symptoms, how the disease is spread and treated, and the side effects of the medication. The work includes giving skin tests at the homes of refugees who are at lower risk of having the disease. Outreach workers, however, do not work independently as medical troubleshooters. "If a patient is having a problem, they call the clinic and talk to me," says Julie Wallace, a registered nurse who manages the Refugee TB Prevention Program. "And if I'm not available, they talk to another nurse."

The outreach workers first meet their patients at the health department's TB clinic at Harborview Hospital

"WHEN YOU'RE DOING ETHNOGRAPHIC RESEARCH, AND CHARACTERIZING ATTITUDES, BELIEFS, AND PRACTICES IN COMMUNITIES, THE CHALLENGE IS NOT CREATING A CARTOON OF THOSE COMMUNITIES."



or at one of the institution's other clinics that provide primary care. It is an anxious time for new refugees. Although they have already had a chest x-ray before arriving in the United States, and an initial TB screening in this country, many refugees are still apprehensive that any official encounter might lead to being returned to their homeland. "I'm one of the first people who they meet from their country," says Jasmin Cokic, an outreach worker who was born in Doboj, Bosnia-Herzegovina, and arrived in the United States in 1997. "I try to establish some friendly relationships with them — not only to talk about TB and prevention of TB. I also try to help them with their other needs like schools for children, jobs for adults."

After health care providers see the patients, get their medical histories, and prescribe INH for those who need it, outreach workers make monthly deliveries of medication to the homes of refugees. The visits also provide an opportunity for outreach workers to talk informally about latent TB infection and its treatment.

CONNECTING TO DOT IN BALTIMORE

Using an effective form of TB treatment in which health care providers watch patients take all of their daily medication, the Baltimore City Health Department reduced rates of tuberculosis by more than 60 percent between 1978 and 1992. The city's program of directly observed therapy (DOT), according to a report recently published in *The International Journal of Tuberculosis and Lung Disease*, generated health care savings equal to "twice Baltimore City's total TB control budget during the study period."[2]

"Daunting and Confusing"

Perhaps the largest single obstacle to effective TB control in the United States is the failure of patients with active TB disease to complete their antibiotic therapy. The standard treatment for such cases is four drugs over two months, then two drugs over four months. Taking the medication is "quite complicated," write the authors of the new Institute of Medicine report *Ending Neglect: The Elimination of Tuberculosis in the United States*. "Daily ingestion of the eight or nine pills often required during the first phase can be a daunting and confusing prospect."

Ironically, the task of completing therapy is further complicated by the effectiveness of the medication. Within a few months of starting treatment, and sometimes within a few weeks, the persistent cough, weight loss, and other symptoms of TB disappear. Some patients believe they are cured and stop taking the antibiotic treatment. But the TB bacteria are stubborn, and it takes six months or more to kill them. Incomplete therapy increases not only the risk of a relapse, but also the resistance of TB bacteria to the medication. The drug-resistant TB can then be spread to others.

Starting in 1958, when the Centers for Disease Control and Prevention first began reporting rates of tuberculosis by city, and for the next 20 years, Baltimore ranked second or third highest in rates of TB disease among large U.S. cities. In 1978 the Baltimore City Health Department started a program of directly observed therapy in the city's five chest clinics. When antibiotic therapy is taken as directed, 90 percent or more of patients are cured.

Focusing on Neighborhoods

The Baltimore DOT program initially targeted high-risk patients, then defined as people who were unemployed, homeless, or alcoholic. Offering free medication and transportation, this clinic-based approach treated about 25 percent of the city's TB cases. In 1981 the program began a critical expansion from the city's public clinics to its neighborhoods — in schools, workplaces, and homes. By 1992, almost 80 percent of the city's TB cases were being treated with DOT.

Between 1978 and 1992, the TB rate in Baltimore declined by 64.3 percent. Without DOT, the authors estimate, the city would have had between 1,500 and 2,200 more cases of TB. The additional health care costs for treating these cases would have been between $18 million and $27 million. These results are all the more impressive because much of the progress was achieved when Baltimore experienced a rise in poverty, AIDS, and other TB risk factors, and the United States as a whole experienced an unexpected increase in tuberculosis cases.

A city that was perennially among the top three cities for TB cases dropped to twenty-eighth in the 1990s. The authors ended their analysis in 1992 because of changes in the way TB data are collected. They note, however, that DOT participation rates increased in the 1990s and that extending their analysis would show additional savings.

Like the Refugee TB Prevention Program in Seattle, the Baltimore DOT program demonstrates the power of community-based approaches to health care. "The neighborhood is the focus of the work," says Patrick Chaulk. "You build these programs around the patients and the clients, and you involve families in the work."

[2] "Modeling the Epidemiology and Economics of Directly Observed Therapy in Baltimore," C.P. Chaulk, M. Friedman, and R. Dunning, *The International Journal of Tuberculosis and Lung Disease*, March 2000.

Outreach worker Mohamed Jama, who was born in Mogadishu and came to the United States in 1996, says he is often asked by his patients: "'Do you remember that the doctor said that I don't have the disease? How come the Americans are telling us that we are not sick, and at the same time they are saying take the medication for six months?' It takes me almost an hour to convince them that it's preventive and good for them."

Jasmin Cokic, who often drives more than 100 miles a day to deliver medication to his patients, also has patients who need coaxing to complete their treatment for latent TB infection. "Bosnians favor herbs," says Cokic. "When they have the flu, they will take lemon and they will take honey and mix that with milk. That's the medication for flu. We have a good diet — lots of fruits and vegetables. The Bosnians say, 'Health enters through the mouth.'"

What many Bosnians don't want entering their mouths is factory-made INH every day for six months. "Patients always tell me, 'It's too hard for me. I cannot take medication anymore,'" says Cokic. "And I always need to encourage that patient to continue to take that medication. That it is very important to finish that therapy of six months."

Institutional Change

In the targeted communities, the Refugee TB Prevention Program is conducting focus group research that examines barriers to effective tuberculosis prevention. Small groups of six to eight refugees meet with project staff to discuss TB, good health, and other medical topics and cultural beliefs. To date, the project has completed six Bosnian and six Somali focus groups, as well as a number of individual interviews. The Russian focus groups are currently getting under way.

"We explore traditional treatments of the disease, what people do to seek care when they're sick," says Julie Wallace, who coordinates this qualitative research. "We really focus on what happened before they came to the U.S., and then we talk a little about their interaction with the health care system here."

The immediate goal of the focus groups is to produce reports, videos, and other materials to train health care workers. A longer-term goal is promoting institutional change in the provision of culturally sensitive medical care. "The fact that the medical directors and the researchers are going to great pains to listen to the community begins to filter down to the nurses and the front-desk staff," says Jackson. "And they begin to say, 'OK, we know more about the individual populations. We know to treat Somalis differently than we treat Ethiopians. We understand the tensions. We understand some of the larger dynamics.'"

Jackson cautions that a major challenge of the focus group research is avoiding stereotypical conclusions about immigrants. "When you're doing ethnographic research, and characterizing attitudes, beliefs, and practices in communities, the challenge is not creating a cartoon of those communities," says Jackson. "They are very diverse, sophisticated communities that draw upon their own traditions and upon contemporary life."

"Multitasking"

To date the Refugee TB Prevention Program has screened more than 2,000 people. In contrast to the previous completion rate of 25 percent, the new rate of 88 percent has attracted the attention of the Institute of Medicine and others. "We are highly enthused by what we are seeing," says Charles Nolan, who recently presented preliminary findings of the project to the American Thoracic Society, an educational and scientific organization that focuses on respiratory care and life-threatening acute illnesses.

The early success of a relatively small demonstration program always raises a number of tough but legitimate questions: Are the results of the project sustainable? Is the program cost effective? How do you increase the scale of the project's impact so that more people can reap its benefits?

Only time will tell if the impressive numbers of the Refugee TB Prevention Program are sustainable. When the final medical results are in, the project will analyze whether the benefits of increased compliance are higher than the costs of the program.

As for increasing the scale of the project, Carey Jackson uses a computer metaphor — "multitasking" — to describe a possible next step. He envisions an approach where outreach workers combine their TB work with other prevention efforts in public health as well as with case management of a range of health and social services for high-need communities. "A combined model that would do public health education and service delivery case management," says Jackson, "could be a very effective way to address the cost issues in this country around health care."

Bill Rust is the editor of ADVOCASEY.

HEALTH CARE FOR ALL

MEDICAID AND CHIP OUTREACH IN NEW ORLEANS

BY MICHAEL DeCOURCY HINDS

It's late June in New Orleans, and a meteorologist on WWL-TV calls for a steam bath that will feel like 106 degrees. By late morning the sun is already scorching the St. Thomas housing development, and Melvina Johnson, an area resident and social service worker, points out the absence of air conditioners in the windows of the circa 1940 housing project. It is a monotonous grid of 172 squat brick buildings, mostly derelict and exuding despair. The occasional flowering bush or tree softens the scene but the hints of nature also dramatize its bleakness.

Johnson is out in the morning heat because she's an outreach worker for the St. Thomas Health Care for All program, based in Kingsley House, the area's 104-year-old settlement house. It's a small program, involving a full-time coordinator, Tammi Fleming, and three part-time workers who go door-to-door in the housing community, helping parents to sign their children up for public health care insurance.

The year-old experimental program, sponsored by the Annie E. Casey Foundation and assisted by a Boston nonprofit organization called Health Care for All, is an effort to reach some of the nation's most disadvantaged families who can't or won't navigate the public assistance system. Many St. Thomas kids lack health insurance, reflecting a national problem involving millions of eligible children who are missing out on public insurance and the comprehensive care that goes with it.

"It's partially a communications problem," says Dr. Patrick Chaulk, a senior associate at Casey who manages the Foundation's health grant making. "My perception, as a physician, is that we don't take into enough account the importance of the messenger. It's particularly important for poor families who tend not to trust public systems. With this program, we wanted to see if a different messenger, someone credible from the community, would make a difference."

Chaulk says people are more receptive to sharing sensitive information with peers in their own community. That lesson was learned in a recent Casey initiative, called Plain Talk, which focused on reducing teen pregnancy and sexually transmitted diseases. (See page 18.) Now the Health Care for All program is applying this approach to children's health by sending paid outreach workers door-to-door in their own communities. Trained by city Medicaid officials, Johnson and her colleagues who do all this walking and talking call themselves, quite naturally, walkers and talkers.

Helping community residents like Johnson to deal with their own neighborhood problems, rather than contracting with an outside agency to serve their needs temporarily, makes the most sense in the long term, says Chaulk: "What we've learned is that most of the successful things Casey has done have involved putting the target population in the driver's seat, giving them the tools and resources and support, and letting them do it their way."

A Critical Safety Net

Nationally, one in seven children lacks health insurance, representing 11 million of the 44 million uninsured Americans. Typically, that means these kids receive no care for their teeth, eyes, or hearing; few preventive screening exams; and little or no treatment at the early stages of health problems. For most of them, medical care is a last resort, often associated with severe illness, frantic parents, frustrated physicians, and long waits in emergency rooms of public hospitals. In such settings, there is often a question about quality of care.

"I had to go back to the charity hospital three times before they would admit my son, Carlos," says Peola

McKinnis, a 22-year-old food service worker at the University of New Orleans who could not afford to purchase insurance at work. "I just knew something was wrong with him, and it turned out to be a respiratory virus." A walker-talker subsequently signed McKinnis's son up for health insurance, and he's now receiving free prescriptions and preventive care.

Health insurance is a critical safety net for children. In a 1999 national survey, sponsored by the Kaiser Commission on Medicaid and the Uninsured, 41 percent of parents of uninsured children said they postponed seeking medical care for their child because they could not afford it. Inferior medical care is linked to unnecessarily serious health problems and, indirectly, to children failing in school due to poor health and extended absences. And, of course, school failure is linked to every social ill in the book.

America's health care problems include many paradoxes, including the estimate that 7.3 million of the uninsured children may suffer needlessly because they are eligible for public health insurance. They qualify for Medicaid or another joint federal-state insurance called State Children's Health Insurance Program, which is generally known by the acronym CHIP.

In Louisiana, as in other states, there is a symmetry in the high rates of poverty, health problems, and the lack of insurance coverage among children. In 1997, for example, 28 percent of low-income children in Louisiana were uninsured (versus 25 percent nationally), according to the most recent national *KIDS COUNT Data Book*. Thirty-four percent of the state's children under five lived in poverty (versus 23 percent nationally), and the state's child death rate was 34 per 100,000 children (versus 25 per 100,000 nationally).

Why are so many parents failing to enroll children in the free health care plans? The benefits, it turns out, are often surrounded by bureaucratic barbed wire, the stigma of welfare, and misinformation. Nearly all of the low-income parents surveyed by Kaiser said it was very important to have health insurance for their children, and two out of three parents said they had applied for Medicaid. But more than half of those attempts were unsuccessful because most parents found the process to be a complicated, confusing hassle.

Applying for Medicaid has usually meant going to a public agency during working hours, filling out a 15- to 30-page application as often as every six months, and submitting numerous documents such as pay stubs for

Two out of three low-income parents surveyed said they had applied for Medicaid. But more than half of those attempts were unsuccessful because most parents found the process to be a complicated, confusing hassle.

Congress created CHIP in 1997 and authorized spending $40 billion on it over ten years to provide a safety net for poor children, including those who lose transitional Medicaid benefits a year after their parents leave welfare for work. (The remaining 3.7 million uninsured children are ineligible because their family income exceeds state limits, which vary between 150 percent and 200 percent of the official federal poverty level — 200 percent equaled $33,400 for a family of four in 1999. These ineligible children are caught in a Catch-22: Their parents earn too much to qualify for public insurance and earn too little to buy private insurance at work or elsewhere.)

eight consecutive weeks and actual Social Security cards, not just Social Security numbers. Small fluctuations in income often mean periodic interruptions in coverage and the hassle of reapplying. These eligibility requirements, with their historical links to welfare eligibility, made little sense for a health care program intended to reach as many children as possible.

The problem of children's health care became more visible after welfare reform in 1996, when the number of covered children plunged for many reasons, including states' computer errors, confusion about transitional health care programs, and families' frustration with the public system. In response, the federal

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government, which sets few requirements for the enrollment process, encouraged states to revise enrollment policies and promote the new CHIP program, which has a two-page application and higher income allowances.

States have taken steps to streamline the process, including some that presume a child is eligible if he or she participates in a comparable public program such as food stamps or school lunch. But paperwork problems persist nationally, and many families don't have accurate information. In the Kaiser survey, the majority of low-income parents who had not tried to enroll their children believed they were ineligible, didn't know how or where to apply, said the rules and forms were too complex, and feared being treated with disrespect at public agencies.

A major philanthropic initiative to enroll eligible children is Covering Kids, funded by the Robert Wood Johnson Foundation. Operating in all 50 states, Covering Kids supports state and local coalitions that seek simpler, but still rigorous, application processes and that conduct outreach and communication campaigns. In a number of states, the lead organization for Covering Kids is one of the Casey Foundation's state grantees for KIDS COUNT, which provide county- and community-level data on critical facets of children's lives.

The Casey Foundation's support for the walkers and talkers is intended to complement the work of Covering Kids and other policy and advocacy initiatives by demonstrating an effective way of reaching out to disadvantaged families in tough neighborhoods. The initial success of the program has attracted interest among community leaders in Baltimore, Boston, Denver, Oakland, San Diego, and Washington, D.C. In New Orleans, the next step will probably be an expansion of the program to other public housing projects in the city.

An Adaptable Model

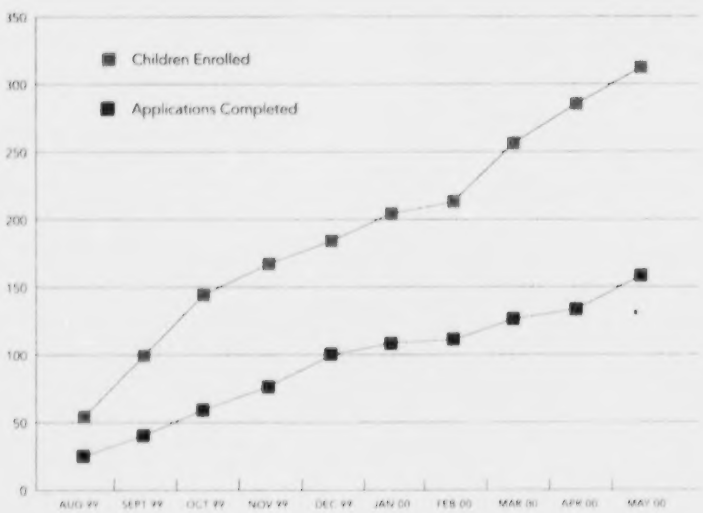
For now, the outreach program is focused on the St. Thomas housing community. It is an island of poverty, surrounded by a rapidly gentrifying neighborhood called Irish Channel and the adjacent Garden District, the city's tourist attraction of opulent antebellum mansions and manicured lawns. Originally built for 2,700 white families, the housing community was desegregated in the 1960s, becoming nearly all African American.

This is a neighborhood of staggering contrasts: It has the city's wealthiest people and its poorest, and it has the highest rate of high-school dropouts and the highest percentage of people with graduate degrees. And in the early 1990s, when urban crime rates soared, as many as 35 people a year were killed in St. Thomas

BY THE NUMBERS THE IMPORTANCE OF THE MESSENGER

In the Health Care for All program in New Orleans, community residents go door-to-door to sign up eligible families for public health insurance. Between August 1999 and May 2000, a largely part-time staff of four contacted 1,623 households in the St. Thomas housing development, conducted surveys of 1,136, and enrolled 312 children in 158 families.

Source: St. Thomas Health Care for All



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housing alone, usually over drugs. Around that time the city decided the best way to solve St. Thomas's problems was to demolish it and replace it with a mixed-income development. As the plan evolves, however, fewer and fewer of the apartments are being set aside for low-income people. In any event, most families have now been relocated to other public housing and the remaining 450 families are scattered around what looks like a ghost town with many boarded-up doorways and windows.

Social workers and county health officials from San Diego braved the New Orleans heat in late June to attend a two-day workshop on Health Care for All. They had long, enthusiastic discussions about the program. They talked about how they might use it, not as a cookie cutter they would bring home, but as an adaptable model for engaging community residents in solving children's health care issues, including insurance coverage.

One unanswered question was how to make such a program self-sustaining. "When I look at a program like this, I'm already down the road about three years thinking about funding," said W. Harold Tuck, deputy director of San Diego County's Health and Social Services Agency. "The county could help get it going, but couldn't support it long term. Money would have to come from somewhere, probably in little bits from many places, kind of like a Creole recipe. But it's an effort that can be justified in many ways if, say, it helps keep people off welfare, helps kids stay healthy, and reduces health costs by not using emergency rooms so much."

A highlight of the workshop was getting a firsthand look at how walker-talkers like Melvina Johnson go about their work in St. Thomas. "I give a friendly knock, knocking out a little chime," Johnson explained to the visitors as she stood in front of typical two-story house on St. Andrews Court. In the prior nine months, Johnson had knocked on this door five times without getting an answer or a response to the business card she always left behind. Today was different. A woman stepped out onto a second-floor balcony.

"Hi, how you doing, baby?" Johnson called out. "I'm from Kingsley House, and they're offering free medical insurance. Do you have an insurance card? No? Come on down, and I'll give you some information."

As it turned out, the 40-year-old woman lived alone, was out of work, was not on welfare, had no health insurance, and was eight months pregnant. She was interested in signing up for the CHIP insurance program. Johnson's customary routine includes helping mothers or fathers fill out the application, collecting the necessary documents, making copies of them at Kingsley House, and returning the originals to the family within an hour. In this case, the woman didn't feel comfortable handing over her important papers, but said she would bring them to Kingsley House at noon.

"OK, I'll be there at 12, and if you're not there I'll be back here at 12:15," Johnson said in a joking but firm way. Privately, Johnson predicted that the woman would not make the appointment. She was, however, totally sympathetic: "Would you go outside in this heat if you were eight months pregnant?" Her prediction proved correct.

On the return trip to St. Andrews Court at 12:15, Johnson didn't mention the missed appointment and acknowledged a paperwork problem. "I came around to keep you from coming out in this heat," she told the woman. "I didn't have the right application for you, but if I luck out and find one, I'm going to get you signed up today. And if I come to get you, we'll ride in my car."

The paperwork problem was this: Johnson didn't want to put the woman through the 14-page Medicaid application process required by Louisiana, and she didn't have the appropriate CHIP application. The state, which recently expanded CHIP coverage to pregnant women, had not yet distributed the proper forms.

Despite such glitches, Health Care for All shows promise. In the program's first ten months, the largely part-time staff of four contacted 1,623 households, conducted surveys of 1,136, and signed up 312 children in 158 families. And because of the training provided by the city, the application process is both more efficient, reducing the typical approval time of two months to two weeks, and more accurate. Thus far, only one application has been returned for having incorrect information.

Numbers, however, can't convey the suffering many uninsured families feel or the relief the walkers and talkers bring. "One lady's son was real sickly," said Tammi Fleming, the program coordinator. "She was a working mother, and had five or six medical bills she couldn't afford to pay. We helped her get her documents, did everything we needed to do, and she got her insurance card within two weeks. She was real happy."

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THE CAPACITY TO HEAL

THE REBIRTH OF A COMMUNITY HEALTH CENTER IN RICHMOND

BY BILL RUST

The federal government pulled the plug on Richmond's East End Community Health Center on January 31, 1998. The clinic, which received about half of its funding from the U.S. Department of Health and Human Services, was denied further federal support because of a number of internal problems. High turnover among the center's providers, for example, precluded the continuity of service essential to effective primary care. The center was also unable to market itself as a resource for the medically underserved East End community.

Although the closing of a federally funded health center is rare — in the last three years only one of the 70 or so such centers in the mid-Atlantic region was denied funding — the response of the East End community was perhaps no less extraordinary. Residents, city government, and an array of private and public organizations worked together with remarkable speed and efficiency to form a new nonprofit organization, elect a new board, write the application for federal funding, renovate the facility, and hire a staff. "It was an incredible example of what can be done when you have the commitment and the will and have built capacity," says Cynthia I. Newbille, East District Manager for the City of Richmond.

The new clinic, the Vernon J. Harris East End Community Health Center, opened for business in March 1999. Named after a revered African-American physician who practiced family medicine in the neighborhood earlier in the century, the center has already served many more residents than the old clinic did in three years. "Given all the [previous] turmoil," says Scott Otterbein, who is an official with the federal Bureau of Primary Health Care, the new center is "doing phenomenally."

The East End

A community of some 27,000 residents, 90 percent of whom are African Americans, the East End of Richmond is rich in history. It was here at St. John's Church on East Broad Street where Patrick Henry issued his famous ultimatum "give me liberty or give me death." And in some parts of the community, there are architecturally significant 19th-century homes that have been painstakingly restored.

But there are also many boarded, vacant homes in the East End, which has some of the poorest neighborhoods in Richmond. Four of the city's seven major public housing communities are located there, and about 40 percent of the neighborhood's residents live in poverty. Drug dealing and violent crime are problems in many parts of the area.

More than a quarter of the community's residents between the ages of 18 and 64 do not have any health insurance, according to the Survey & Evaluation Research Laboratory at Virginia Commonwealth University. As with many low-income neighborhoods, the residents of the East End have high rates of hypertension, diabetes, and other chronic conditions that are either preventable or controllable with good primary care. In the absence of such care, children and families frequently find themselves in hospital emergency rooms.

Responding to the economic, health, and other challenges of the community, the City of Richmond established the East District Initiative in 1993. Seeking to bring services closer to the people who need them, the East District Initiative includes a satellite city hall as well as housing and economic development programs. The goal of the initiative, says Cynthia Newbille, is "to reinvent the ways services are delivered to the community."

The East District Initiative was a key reason that Richmond was selected in 1993 as a site for the Annie E. Casey Foundation's Mental Health Initiative for Urban Children. In neighborhoods with many needs, few services, and unpredictable and pervasive violence, children are at especially high risk for emotional and behavioral disorders. The Mental Health Initiative for Urban Children helped states, localities, and neighborhoods work together to rethink their mental health services — for example, by emphasizing prevention and community-based care rather than expensive and often ineffective institutionalization. One goal of the mental health initiative was to develop a blueprint for a neighborhood-based system of care that could address the multiple and interrelated problems often experienced by disadvantaged families.

"Accessible and Easy"

In Richmond, a key accomplishment of the mental health initiative was the establishment of the East District Family Resource Center, which families in the community had identified as a critical need. Providing information, social opportunities, and a wide range of supports for families, the Family Resource Center integrates mental health services into a nonstigmatizing setting. Mark A. Hierholzer, executive director of the Memorial Child Guidance Clinic, which provides counseling and staff training at the center, says the "notion is to provide these services so that they are accessible and easy for clients to approach."

Perhaps the most enduring legacy of the mental health initiative in Richmond is the East Team Board, a neighborhood organization capable of taking ownership of community problems and helping design the means of addressing them. Primarily made up of residents active in civic affairs and tenants' associations, the East Team Board and its related neighborhood groups effectively advocate on behalf of the community and work with public and private agencies. "Because of the Mental Health Initiative for Urban Children," says Torey Edmonds, who chairs the East Team Board, "we have been able to be active in key decisions that impact this community."

"The System Worked"

When the old East End Community Health Center was denied further federal funding, the East Team Board played a key role in preventing the permanent loss of a critical health resource. Organizing a grassroots campaign to gain support for a new clinic, the East Team Board worked with a range of public and private organizations, including the City of Richmond, the NAACP, the Virginia Primary Care Association, and elected officials. Because the governing boards of community health centers must be made

RESIDENTS, CITY GOVERNMENT, AND AN ARRAY OF PRIVATE AND PUBLIC ORGANIZATIONS WORKED TOGETHER WITH REMARKABLE SPEED AND EFFICIENCY TO PREVENT THE PERMANENT LOSS OF A CRITICAL HEALTH RESOURCE.

"One of the challenges for health care is building bridges into the community. You have to establish trust so that people feel comfortable and confident about having their health care needs met here."

up of people who use the clinic for their personal health care, the East Team Board helped identify residents who could serve effectively on the board of a new clinic.

Given the sometimes glacial pace of change in federal-state-community partnerships, the new Vernon J. Harris East End Community Health Center quickly moved forward. Incorporated as a nonprofit organization in May 1998, the clinic announced two months later that it had received a planning grant from the federal government. "The system worked," says Scott Otterbein. "The NAACP, the East District Initiative, groups that Casey had been working with had a better understanding of the right combination of community-based advocacy and community-based expertise."

To help prepare for their responsibilities, board members of the clinic visited the Neighborhood Health Care Network, a Casey Foundation grantee in Minneapolis, to learn more about the organizational, operational, and fiscal challenges of operating a comprehensive community health center. "Like any organization, you need to have a strategic plan in place," says Dr. Patrick Chaulk, senior associate for health at the Casey Foundation. "You need to know who your clientele are likely to be and what their health needs are. You have to figure out how the marketplace is going to affect you — managed care, hospital closures, insurance coverage — and then make sure you have the resources for the services you want to provide."

A major marketing challenge for the new health center was overcoming local misconceptions that the new clinic was really the same old clinic with the same indifferent service. To help dispel such notions, the center held an open house in December 1998 for business, civic, and church organizations to alert the community that it would soon be open for business. "We had to get past the history of the prior entity," says Cynthia Newbille, who serves on the Harris clinic board. "We had to get the word out that not only were we back, but there is a new entity that is committed to quality service."

Because of its commitment to providing employment opportunities in the community whenever possible, the East District Initiative hired unemployed fathers with trade skills to help renovate, paint, and clean the clinic, which is leased from the city. The gutting of a city-owned building for the East District Family Resource Center provided a similar opportunity for community residents, who were trained and certified for asbestos removal.

"Building Bridges"

On March 15, 1999, the Vernon J. Harris East End Community Health Center opened its doors to the public. Providing a wide range of primary care services for people of all ages, the clinic has two full-time doctors: a medical director, who is a pediatrician, and a family practice physician. The Annabella R. Jenkins Foundation, which supports health care programs in the greater Richmond area, has provided funding for dental care. The clinic anticipates employing a physician specializing in obstetrics and gynecology in the near future.

In a community where approximately 15 percent of the population are seniors, the Harris clinic provides a vital service by monitoring their overall health and prescribing medication when necessary. Because of an arrangement with a local pharmacy, the clinic buys prescription drugs at cost, providing medication for people who would not otherwise get it. The clinic also provides free flu vaccines, lead screening, and other preventive

care. To prepare for the coming school year, the clinic will provide physicals for as many as 1,000 kids on August 26, 2000.

In sum, the health center provides a high-quality service that is open to all. It is not, however, a free service. For people without insurance, there is a sliding scale of fees based on income and family size. No one is turned away for lack of funds, and the clinic has served more than 3,000 people since its opening. For some patients, it was the first time they had seen health care providers who were not emergency room staff.

Seeking to take its services even deeper into the community, the clinic is considering the possibility of creating satellite sites in the community's housing developments. "One of the challenges for health care is building bridges into the community," says Sheena Mackenzie, executive director of Vernon Harris. "You have to establish trust so that people feel comfortable and confident about having their health care needs met here."

A Neighborhood System of Care

A community health center, in and of itself, is obviously incapable of solving all the social problems of a low-income neighborhood or even all of its health problems. Such clinics can, however, serve as part of larger neighborhood systems of care addressing the multiple needs of many disadvantaged children and families. The idea is to have the health center linked and integrated with other community resources — for example, the East End Teen Center, located in the basement of the clinic, the Family Resource Center across the street, and the satellite city hall across the parking lot.

But the challenge of a neighborhood system of care is more than just conveniently co-locating services. It involves looking at families holistically, providing case management and seamless referrals from one agency to another, and using technology to share information and monitor progress. The East End of Richmond has not yet fully developed such a comprehensive network of services, but the pieces of such a system are beginning to fall into place. The community health center "is the beginning of a neighborhood system of care," says Torey Edmonds. "We are trying to provide for all the needs that one family might have."

MINORITY HEALTH

When asked what the Vernon J. Harris East End Community Health Center means to the Richmond neighborhood, East District Manager Cynthia I. Newbille replies, "I think it means the difference between life and death for people." Reflecting on this predominantly African-American community's high rates of chronic diseases that are controllable with primary care, Newbille echoes an observation of the U.S. Department of Health and Human Services: "For too many racial and ethnic minorities in our country, good health is elusive, since appropriate health care is often associated with an individual's economic status, race, and gender."

There are six key areas of health where ethnic and racial disparities are most prevalent — infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and childhood and adult immunization:

- The infant mortality rate for African-American infants is more than twice the rate for white and Hispanic infants (13.7 deaths per 1,000 births vs. 6 deaths per 1,000).
- The prevalence of diabetes among African Americans is about 70 percent higher than whites and the rate for Hispanics is nearly double that of whites.
- Compared with rates for whites, coronary heart disease mortality was 40 percent higher for African Americans in 1995.
- African Americans have a cancer death rate about 35 percent higher than that for whites.
- While racial and ethnic minority groups account for about 25 percent of the population, they account for more than 50 percent of all AIDS cases.
- Only 74 percent of African-American children and 71 percent of Hispanic children have received the complete series of childhood immunizations by age two.

Source: U.S. Department of Health and Human Services Fact Sheet, "HHS Strategies for Improving Minority Health," April 2000.

WALKING THE PLAIN TALK

PROTECTING SE[illegible] [illegible]IVE TEEN[illegible] [illegible]A, NEW ORLEANS, AND SAN DIEGO

When the topic is teen sex, it is sometimes hard to tell whether Hollywood or Washington, D.C., has a more tenuous grasp on reality. Movies, television, and other forms of popular culture often promote a go-for-it message that skips lightly over the possible negative consequences of sexual intercourse. Rarely does the sexual behavior of characters in entertainment media reflect the experiences of the 900,000 teens who become pregnant each year, or the three million adolescents who are annually infected with a sexually transmitted disease (STD).

Federal lawmakers have been sending teens a message that is more idealistic than Hollywood's, but perhaps no more realistic: no sex until marriage and no protection other than abstinence. The landmark welfare reform legislation of 1996 provides $250 million over five years for abstinence-only education programs that may not provide information about contraception — even though most adolescents in their mid- to late-teens are sexually active, and even though sexually active teens who do not use contraceptives have a 90 percent chance of creating a pregnancy within one year, according to the Alan Guttmacher Institute, a policy research organization that focuses on reproductive health.

The American public has a more complicated — and at times contradictory — view of teen sex than either the entertainment industry or many lawmakers. In *Dubious Conceptions: The Politics of Teenage Pregnancy*, sociologist Kristin Luker writes that "most adults seem to have a clear first choice — namely, that teens should not have sex. At the same time, a large majority of them support contraceptive and sex education programs for teens, a fact that suggests that they doubt that they will get their first choice."

Ambivalent American attitudes about teens and sex are reflected in other beliefs that are not completely consistent. For example, despite overwhelming public disapproval of teen pregnancy, many Americans believe adolescents should have parental permission to obtain contraceptives — a condition likely to discourage many youth from seeking protection. And despite widespread concern about the health risks posed by unprotected sex, relatively few parents overcome their discomfort with the topic and speak to their children about sexual behavior. "It's a subject we don't talk very much about," says Luker, who is currently working on a study about parents' expectations of sex education. "People don't really have a language to talk about it."

Although survey research shows that kids want factual information and help making sense of mass-media and other messages about sex, society's ambiguous and conflicting attitudes discourage them from discussing the topic with parents and other adults. "Without anyone — whether it's a parent or a broader community — to have a balanced conversation about these issues, young people are left to their own devices to get that information," says Barbara Sugland, cofounder of the Center for Applied Research and Technical Assistance.

Teen Pregnancy Rates "Akin to Bulgaria"

Many researchers and advocates contrast the conflicting messages received by teens in the United States with the single, unambiguous message conveyed to their counterparts in Western Europe: "Safe sex or no sex." According to a recently published report on adolescent sexual behavior in the Netherlands, Germany, and France,[1] Europeans tend to view sexuality pragmatically, as both "a normal part of growing up *and* [emphasis in original] a responsibility to protect oneself and others."

To many Americans, such a frank approach to adolescent sexuality would seem an open invitation to

[1] *European Approaches to Adolescent Sexual Behavior & Responsibility*, Linda Berne and Barbara Huberman (Advocates for Youth: 1999).

licentious behavior. In reality, the average age of first intercourse in France, Germany, and the Netherlands is — depending on the country — a year or two older than the United States average of 15.8 years. Perhaps more important, Western European teens are more sexually responsible than their U.S. counterparts, who have much higher rates of pregnancy, STDs, and abortion.

The United States — despite a 17 percent decline in teen pregnancy rates in the 1990s — continues to have one of the highest adolescent pregnancy rates in the developed world. According to a February 2000 study by the Alan Guttmacher Institute, the U.S. teen pregnancy rate is at least four times that of France, Germany, and Japan. In a prepared statement released with the study, the institute reports that current U.S. rates of teen pregnancy "are akin to those in the Russian Federation and several Eastern European countries, including Bulgaria."

Researchers at the Guttmacher Institute, youth advocates, and others believe that the United States can learn much from the Western European approach to adolescent sexuality. Instead of looking at it as a moral failing or a political topic, Europeans approach sexuality from a developmental and public health perspective. This point of view, which is reinforced by mass media and by open access to reproductive health care and contraceptives, guides national efforts to provide adolescents with the knowledge and services to protect themselves. Barbara Huberman, director of training and sexuality education at Advocates for Youth in Washington, D.C., says that the Western European approach acknowledges that "all adults have a role in communicating with teens about prevention and protection."

Plain Talk

Unambiguous adult messages about protecting sexually active teens and access to age-appropriate adolescent health services were core principles of Plain Talk, an initiative of the Annie E. Casey Foundation to reduce teen pregnancy and STDs in the United States. Because of the size of this country, the diversity of its population, and other factors, simply cloning the Western European experience was neither possible nor desirable. Instead, the Casey Foundation sought to adapt European principles of clear communication about protection to a neighborhood-scale initiative that engaged a broad range of community adults in receiving and disseminating accurate information about adolescent sexuality and contraceptives.

"Plain Talk not only looks at parents and children, it also looks at them in the context of communities," says Debra Delgado, a senior associate at the Annie E. Casey Foundation and the Plain Talk initiative manager. "It looks at the networks, the supports, and the resources to help parents in their role as sex educators. At its core, Plain Talk is a communications strategy. What makes it work are the connections between neighbors and institutions and families and young people."

Operating in five neighborhoods[2] between 1994 and 1998, Plain Talk provided more than $5 million in grants and technical assistance for surveying local attitudes, behaviors, and reproductive health resources; training residents to lead community education workshops that help adults speak with youth about responsible sexual decision-making; and improving the quantity and quality of reproductive health care for adolescents. In the three sites where there was extensive ethnographic and outcomes research — neighborhoods in Atlanta, New Orleans, and San Diego — independent evaluators concluded that Plain Talk walked its talk about communication and changing behaviors.

Public/Private Ventures (P/PV), the social policy research organization that evaluated the initiative, recently reported: "The number of sexually active youth who talked with an adult significantly increased, as did their awareness of where to get birth control. These changes in turn increased the use of birth control, decreased the rate of pregnancy and STDs, and increased the number of youth using reproductive health services."

P/PV's follow-up analysis of Plain Talk's outcomes shows that across the three sites:

- pregnancy rates among sexually active girls declined from 54.5 percent in 1994 to 33.6 percent in 1998;
- sexually active youth who had discussed birth control with an adult were about half as likely to create a pregnancy as peers who had no such communication; and
- the proportion of sexually active youth who had spoken with an adult about birth control, pregnancy, or STDs increased from 61 percent in 1994 to 70 percent in 1998.

[2] The Mechanicsville neighborhood in Atlanta, the Stowe Village housing development in Hartford, the St. Thomas housing development in New Orleans, the Logan Heights neighborhood in San Diego, and the White Center neighborhood in Seattle.

Summarizing the Plain Talk outcomes, Jean Grossman, P/PV's senior vice president of research and author of the analysis, says: "Kids who talked to adults more knew where to get contraception. They knew more about it; they felt more comfortable about it. They were more likely to act in a responsible way — both because of talk, but also because they knew where to get birth control. And they were less likely to get STDs and get pregnant if they talked."

The report that follows focuses on three sites where the ethnographic and outcomes research was most thorough. Although the other two sites — neighborhoods in Hartford and Seattle — were less rigorously evaluated, largely because of the high cost of the research methodology, their experiences are still instructive, and some of them are included in this story. "Overall," says Marcia Bayne-Smith, a professor of urban studies at Queens College and a consultant to the initiative, "Plain Talk has been very successful — albeit in different ways in different communities."

"Humbled by Reality"

Because youth at greatest risk of teen pregnancy live in areas with high rates of poverty, all of the Plain Talk neighborhoods selected by the Casey Foundation were low-income communities. According to 1990 census figures, the proportion of residents with below-poverty incomes ranged from 44 percent in San Diego's Logan Heights neighborhood to 86 percent in the St. Thomas housing development in New Orleans. In the three sites where detailed surveys were conducted, the rate of sexual activity among 16- to 18-year-olds averaged 69 percent. The proportion of sexually active girls who were ever pregnant averaged 53 percent.

Despite economic and social disadvantages, each of the Plain Talk communities had sources of local strength that enabled them to take on the issues of adolescent sexuality and protection from pregnancy and STDs. The Logan Heights neighborhood, for example, impressed evaluators as a vibrant community with strong kinship ties and informal networks of friends. The lead organization for Plain Talk, or *Hablando Claro* as it is known in this predominantly Mexican and Mexican-American neighborhood, was the Logan Heights Family Health Center, a comprehensive and innovative provider of health services.

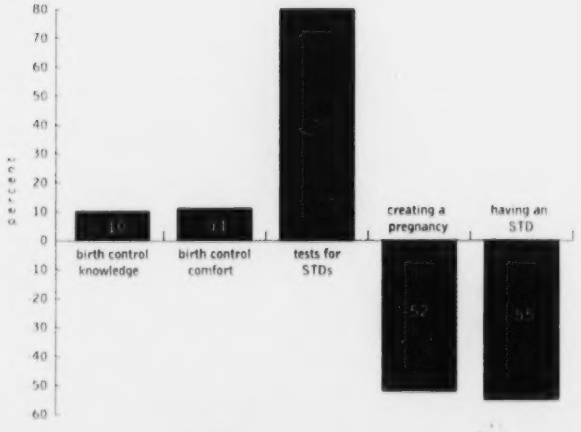
The relatively small size of the neighborhoods, which ranged from 2,500 residents in the Stowe Village housing development in Hartford to more than 13,000 residents in Logan Heights, meant that selling Plain Talk's message would be largely retail rather than wholesale. "The communications are one on one," says the Casey Foundation's Debra Delgado. "It's trusting the person who's coming to talk to you. It's trusting the people who are delivering services to your kids. There's a lot of credibility that needs to be established."

In each Plain Talk neighborhood, one of the first steps was establishing a broad-based planning group of residents, health service providers, and others interested in youth issues. Although professionals were clearly in charge in the early stages of Plain Talk, the most

BY THE NUMBERS COMMUNICATING COUNTS

Plain Talk's evaluators found strong links between responsible sexual behavior and sexually active youth who discussed pregnancy, contraception, or STDs with an adult. Compared with similar youth who did not have such conversations, the talkers were more knowledgeable about birth control, more comfortable with condoms and birth control generally, more likely to be tested for STDs (an evaluation proxy for having a routine reproductive health checkup), less likely to create a pregnancy, and less likely to be treated for — i.e., to have — an STD.

Source: *Public/Private Ventures*



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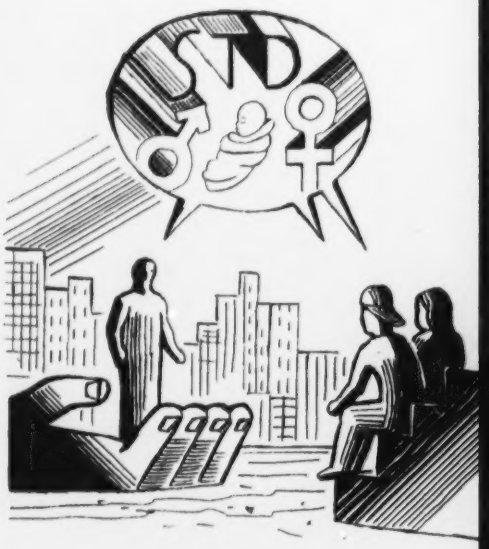
successful sites made a conscious effort to place decision-making authority in the hands of residents, who were both the object of and the agent of this community change effort.

"What we were trying to do was make sure that this initiative belonged to the community," says Cheryl Boykins, CEO of the Center for Black Women's Wellness, the lead organization for Plain Talk in the Mechanicsville neighborhood of Atlanta. "And it took a while," she says, for residents to develop the confidence and skills to make the initiative their own. "We could have been out in front waving a flag. That's what teen pregnancy prevention programs have always done, and when the money runs out, so does the program."

Demetria Farve, who was recruited for Plain Talk by the resident council of the St. Thomas housing development, says her motivation to participate in the initiative came from being a teen mother herself. "I have four daughters, and I knew that I didn't want that kind of a life for them," she says. "So I saw the initiative as an opportunity to not only educate and help the community, but as a way to help educate myself and my family."

Meaningful community involvement in Plain Talk presented a number of challenges to the lead agency in each neighborhood. To make this process work, says Marta Flores, the Plain Talk project coordinator at the Logan Heights Family Health Center, professionals have to be "willing to be humbled by reality. You don't need to always do everything for everyone. People want to do for themselves. And it has been a challenge to allow residents the opportunity to do what they need to do at their own pace. It's easier to say, 'Oh, here, let me do it.' Or 'I've done this before. This is how it works.'"

In addition to programmatic challenges, Cheryl Boykins of Atlanta raises a delicate administrative and fiduciary issue. "How do you balance being an institution that is responsible for an initiative that is intended to be community driven?" asks Boykins. "We were supposed to share everything with the community to the extent that it was community driven, not just community based. So they [residents] saw the budgets, they saw what people made, they saw the money coming in. They thought it was their money. That's hard."



PLAIN TALK PROVIDED FACTUAL INFORMATION AND COMMUNICATION SKILLS THAT HELPED NEIGHBORHOOD ADULTS TALK WITH YOUNG PEOPLE ABOUT SEXUALITY, PREGNANCY, AND STDS.

"What We Believe"

One of the first — and certainly one of the most significant — activities in each Plain Talk site was a survey of community adults and youth by residents. Called "community mapping," this process sought to develop reliable information about local attitudes and behaviors pertaining to teen sexuality, contraceptives, and adult-youth communications. Community mapping also included interviews with service providers to determine the availability and quality of local reproductive health services.

Working with Philliber Research Associates, a firm that helps human service organizations with planning and evaluation, residents not only received training and technical assistance in data collection and analysis, but also contributed to making the survey instruments more accessible and relevant to their communities. In Mechanicsville, for example, focus groups of community adults and youth helped clarify language and made other suggestions to the researchers. And neighborhood adolescents were trained to survey other teens "just in case they didn't want to be interviewed by adults," says Cheryl Boykins.

In every Plain Talk site, community mapping data revealed a high incidence of adolescent sexual activity. In Mechanicsville, for example, 49 percent of the youth ages 14 to 15 were sexually active. A particularly troubling

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finding was that 17 percent of the 12- and 13-year-olds were engaged in sexual activity. "That really alarmed the community," says Jemea Smith, the assistant coordinator for Plain Talk at the Center for Black Women's Wellness.

Community mapping also documented high rates of teen pregnancy in the Plain Talk neighborhoods. In Logan Heights, the proportion of sexually active girls who were ever pregnant was 55 percent. According to P/PV evaluators, the residents there reacted with "a profound sense of sorrow" to survey data indicating that so many of their children had abandoned traditional cultural beliefs about abstinence until marriage. Yet the community mapping data also strengthened the local commitment to protecting youth from pregnancy and disease. "We must do something about it," is the way Marta Flores characterizes the residents' response in Logan Heights. "Our kids need help trying to make better choices. And, yes, we do need to prepare, as adults, to be there for them."

A striking survey finding in all of the Plain Talk neighborhoods was the gap in perceptions between adults and youth. Parents, for example, believed that they spent much more time talking about sexuality than their children did. "What was most astonishing," says St. Thomas resident Demetria Farve, "was that parents thought that they were communicating to their children about sexuality issues, whereas children said that the primary place that they got information was from friends."

In addition to increasing understanding of neighborhood conditions and to deepening residents' commitment to protecting their youth, the neighborhood surveys informed the sites' emerging community education strategies. "Community mapping data have revealed, on the one hand, that youth want communication with, and information from, their parents on sex and sexuality," says Marcia Bayne-Smith, a consultant to Plain Talk who provided technical assistance to the sites. "On the other hand, the data have also shown that parents want help in talking to their children about this subject. A major aspect of this work, therefore, is educating parents and helping them to develop the communications skills they need to talk to their kids."

Plain Talk staffers, initiative consultants, and program evaluators have been unanimous in praising the community mapping component of Plain Talk. Instead of using remote national data about adolescents and sex, community mapping helped residents put a local face on attitudes about adolescent sexual behavior, teen pregnancy, and sexually transmitted diseases. The survey results, says Marta Flores, reflect "what we believe in Logan Heights, the Barrio Logan community. This is what community adults and community adolescents said. It wasn't somebody in Miami or somebody in Albuquerque or in Texas. This was us. So how can we begin to make a better environment, a healthier community for our children?"

"Hard Discussions"

Although gaining consensus about Plain Talk's ultimate goals — reducing rates of adolescent pregnancy and sexually transmitted diseases — was relatively easy, reaching agreement on the means of achieving these goals was not. "At issue," wrote P/PV's evaluators, "was whether Plain Talk should focus exclusively on a message of protection for sexually active youth, whether it should advocate abstinence as the best choice for youth, and whether these two messages could be combined in some way."

Like virtually all American adults, residents in the Plain Talk communities would prefer sexual abstinence for adolescents. In Logan Heights, where this preference was strongest, the combination of survey data and respect for the abstinence point of view helped residents acknowledge that teens who were already sexually active needed protection from pregnancy and STDs. "Plain Talk was a very new and bold step," says Marta Flores. "In the work we have done, abstinence is given as one of the options. But it is also important to remind adults that as we guide our children, we need to be prepared to answer those difficult questions about sexuality, about behavior, about our own values. And even though abstinence is what you want, you know that sooner or later your children will be sexual human beings."

In Mechanicsville, where the abstinence message resonated less sympathetically, there were fears that talk about sex and contraception would actually encourage adolescent sexual activity — despite the absence of any research to support such a belief. "We got over that," says Cheryl Boykins, who characterizes the community consensus this way: "It is unacceptable to bring children into the world that you cannot care for. While we would like you to delay sexual relations, if you are going to engage in sexual intercourse, it is your responsibility to protect yourself from sexually transmitted diseases, particularly the HIV virus, and to protect yourself from conceiving a child you cannot take care of."

Not every community was able to reach consensus on the emotionally and politically charged issue of responding to teen sex. In the Near Eastside neighborhood of Indianapolis, one of the original six planning

sites for Plain Talk, the lead agency withdrew from the initiative after concluding that it could only commit to an abstinence message. And in all of the sites, says Debra Delgado, the early meetings aimed at surfacing thoughts and values about adolescent sexuality were "hard discussions." But, she adds, it was best for all concerned "to have those hard conversations up front."

"Five-Play"

The basic Plain Talk communications strategy was to train a group of residents who could provide both factual information about human sexuality and skills to help neighborhood adults talk with young people about sensitive topics. Some Plain Talk sites emphasized education, others focused on building communication skills. All of them tried to create a "safe space" where residents could informally ask questions and talk with other adults without fear or embarrassment.

Like many American adults and youth, residents in the Plain Talk neighborhoods had significant gaps in their understanding of such topics as human anatomy, the transmission of STDs and HIV/AIDS, and the proper use of contraceptives. And like most parents, residents in these communities found it difficult to speak frankly

BRIDGING CULTURES, BRIDGING GENERATIONS

REACHING OUT TO THE CAMBODIAN COMMUNITY IN SEATTLE

Almost all parents have difficulty talking with their teens about sexuality, pregnancy, and STDs. In the White Center neighborhood south of Seattle, such conversations were particularly challenging for the community's first-generation Cambodian immigrants. Fleeing the Khmer Rouge terror of the late 1970s, the Cambodians had grown up in a culture where parents did not discuss sexuality with their children, where schools did not provide sex education, and where arranged marriages — rather than dating before marriage — were traditional. A Cambodian adult in White Center told P/PV researchers, "In Cambodia, you get engaged — period."

As with most immigrant families, the children of Cambodians in White Center adopted American attitudes and behaviors more quickly and completely than their parents. In some cases, children not only spoke English better than their parents, but also lost the ability to understand the Khmer language. Abandoning the social traditions of their parents, many Cambodian teens in White Center were sexually active and at risk of pregnancy and STDs.

Although White Center includes several cultural and minority groups, Plain Talk made a special effort to reach out to Cambodians, who initially refused to participate in the initiative. Parents were extremely reluctant to discuss sex with their teenage children, and there was a perception in the Cambodian community that Plain Talk "taught people how to have sex," according to P/PV evaluators.

To encourage Cambodian participation, Neighborhood House, a settlement house in Seattle and the lead agency for Plain Talk in White Center, hired Nary Suon, pictured above with her daughter, as an outreach worker. A former teacher in Cambodia, Nary was proficient in English and had worked as a part-time tutor for the Seattle school district. An experienced HIV/AIDS educator, she was concerned with both protecting sexually active youth and preserving traditional Khmer culture.

Nary's first outreach activity for Plain Talk was approaching the Cambodian male elders in White Center, who were an influential source of legitimacy in the community. After her initial overtures were rejected, Nary successfully appealed to the elders' sense of responsibility for youth in the neighborhood, persuading them to drop their opposition to Plain Talk and eventually gaining their assistance in translating the community mapping survey into Khmer.

A key element of Nary's approach was demonstrating her commitment to Khmer culture. These efforts included starting the Kids Society, an after-school and summer program that teaches traditional crafts, performing arts, and respect for elders. Nary also earned the trust of the Cambodian community by assisting families having housing, education, and other difficulties that were beyond the immediate scope of Plain Talk. "When parents have a problem with translation," she says, "I help out with that."

Nary's work was "extremely effective in opening the Cambodian community to Plain Talk," according to P/PV evaluators. An estimated 40 percent of the participants in White Center's Plain Talk for Parents workshops were Cambodians. Moreover, follow-up interviews by researchers indicated that a majority of Cambodian adults who attended the workshops subsequently spoke to their teens about sex, dating, pregnancy, or sexually transmitted diseases.

Summarizing her contribution to helping Cambodian adults adapt traditional parenting practices to the realities of the United States, Nary Suon says simply: "I taught the parents how to talk to their children in the 1990s, and I made the children understand what parents want."

with their own children about sexuality. When asked by her 14-year-old daughter to define the word "foreplay," a term the girl had heard many times on television and in movies, one Plain Talk parent said that her initial impulse was to reply, "It's what comes before five-play."

Atlanta. In Mechanicsville, the community education workshops focused on better parent-child communications about relationships and sexuality. Residents helped recruit their neighbors to attend Plain Talk for Parents workshops by going door-to-door to families with adolescent children. The actual training for residents, however, was provided by professional health educators, who led a series of eight two-hour sessions that included role-playing, discussion, and videos. Some 125 adults, or about 7 percent of the neighborhood's adults, participated in the workshops.

New Orleans. In the St. Thomas housing development, ten residents were trained to be "Walkers and Talkers," who organized home health parties to spread the Plain Talk message and who roamed the community having informal conversations with adults and youth. Among the most requested topics at the home health parties were STDs and HIV/AIDS. Residents were encouraged to call for "a literacy moment" whenever they wanted clarification of an unfamiliar term. The home health parties reached some 800 residents, or 62 percent of the neighborhood's adults.

San Diego. In Logan Heights, six residents were trained as *Promotoras* (peer advocates), who organized small *Vecino-a-Vecino* (neighbor-to-neighbor) workshops in the homes of residents. Larger community education workshops were held in schools or other community centers. Like New Orleans, San Diego focused on factual information — including human anatomy, adolescent development, and the prevention of STDs and pregnancy. Because of traditional cultural reticence about sexuality, residents were encouraged to put their questions in writing, which were answered at a follow-up session. The workshops served more than 1,300 residents, or about 17 percent of the adult population.

BREAKING THE CYCLE IN HARTFORD

In the early 1990s Hartford, Connecticut, had one of the highest teen pregnancy rates of any city in the United States. Nearly one-quarter of the city's babies were born to teen mothers.

Responding to the crisis, city government, the public schools, and a local planning and advocacy organization called the Hartford Action Plan on Infant Health established Breaking the Cycle, a citywide campaign to reduce teen pregnancy and increase educational and career opportunities for young people. Supported by local corporations, foundations, and community organizations, Breaking the Cycle is a comprehensive initiative that includes curricula for elementary schools, public service advertising, community education, and reproductive health services.

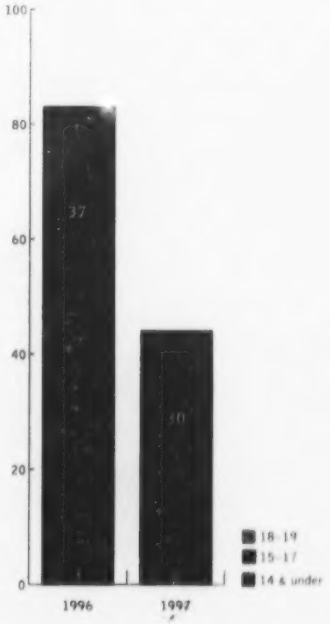
The Breaking the Cycle campaign incorporated principles and activities developed by the Plain Talk site in Stowe Village, a low-income community in north Hartford. Breaking the Cycle's "Let's Talk" program, which helps parents communicate with teens about sexuality, and its teen-friendly clinics, which provide age-appropriate reproductive health services, were based on model programs operating in Stowe Village.

"The influence of Plain Talk was really dramatic," says Flora Parisky, chief operating officer of the Hartford Action Plan on Infant Health. "It made Breaking the Cycle move light-years beyond itself by greatly increasing the explicit emphasis on adults talking to youth and the need for reproductive services."

Parisky says that between 1991 and 1997 the overall teen birth rate in Hartford decreased at a greater rate than the national average. In the Northeast neighborhood of Hartford, which includes Stowe Village, the reductions "were among the largest in the city," she says. From 1996 to 1997, there was a 47 percent decrease in teen births in the Northeast neighborhood. For kids 17 and under, the reduction was 70 percent.

Source: Hartford Action Plan on Infant Health

Teen Births in the Northeast Neighborhood of Hartford, 1996 and 1997



Barbara Sugland, a Plain Talk consultant who helps community-based organizations adapt model teen pregnancy programs to their needs and circumstances, says that neither of the two basic approaches to community education — workshops led by health professionals or lay educators — is inherently better. "The best approach is what is appropriate and comfortable for that community," she says. "This issue is a very personal and a very difficult issue for some communities. In some places, it is important to have residents who are trained to deliver information. They are going to be the only effective messengers. In other communities, you may need outsiders to bring that message."

There were, however, major differences in the presentation styles of the professional and community educators. Professional health educators were more sensitive to the political controversies surrounding sex education, and they maintained a posture of objectivity that avoided value judgments and the appearance of cultural insensitivity. According to P/PV's Karen Walker, who supervised the ethnographic research in Plain Talk sites, the professionals "didn't feel that they had the moral authority to stand up and say, 'We need to protect our youth,' because they would have been saying, 'You need to protect your youth.' You can understand the problem with the patronizing message in such a statement."

Trained resident educators, on the other hand, defined teen pregnancy and STDs as their own problem and the community's problem, and they passionately promoted the importance of protecting sexually active youth. "When the residents delivered messages," says P/PV's Jean Grossman, "there was this sense of both outrage and moral authority: 'You've got to tell your kids to use condoms or they will get these ugly STDs. And look, here are pictures.'"

Reproductive Health Care

Helping parents and other adults provide teens with accurate information about sexuality was one part of the Plain Talk strategy. But because knowledge alone will not protect sexually active youth from pregnancy and STDs, the other part was increasing adolescents' access to quality, age-appropriate reproductive health care, including contraceptive services. The characteristics of such health care include convenient hours for teens, sensitivity to the youth's culture and developmental stage, services for both boys and girls, counseling about contraception, and the availability of contraceptives.

With the exception of Logan Heights, none of the five Plain Talk communities had reproductive health services for adolescents in their neighborhoods. And even in San Diego, the Logan Heights Family Health Center provided reproductive health care for teens only one afternoon per week. Moreover, survey data revealed that local youth had a number of complaints about the services — for example, long delays in getting appointments.

Using information from the community surveys, as well as organized appeals by residents, all of the Plain Talk sites were able to improve adolescent access to reproductive health care:

- In Atlanta, the Plain Talk site worked with the Fulton County Health Department to establish a full-service community health clinic in the Mechanicsville neighborhood.
- In New Orleans, Plain Talk staff in St. Thomas helped a community health clinic develop reproductive health services for adolescents.
- In San Diego, the Logan Heights Family Health Center substantially increased its hours of reproductive health services for teens to four afternoons per week and on Saturday mornings.

In addition to increasing the presence of clinics in the community and expanding their hours of operation, Plain Talk sites sought to make adolescent health care "user friendly." In New Orleans, for example, support from the State Department of Family Planning enabled St. Thomas Health Services to open an adolescent clinic during convenient evening hours, with resident Walkers and Talkers providing informal counseling.

In Logan Heights, the work of Plain Talk, combined with related initiatives funded by the state of California, the Kaiser Permanente Hospital in San Diego, and two private foundations, led to the clinic's purchase of a new teen health center in 1997. "We have an independent building dedicated to teen health services," says Marta Flores. "To have our agency commit a building to adolescent services is fabulous."

Because of their common goal — protecting the health of adolescents — Plain Talk sites and medical professionals were natural collaborators. Working with other community institutions — for example, schools, businesses, and churches — was "a far greater challenge," according to P/PV evaluators.

The absence of meaningful partnerships with community schools was a disappointing but not entirely

"THE NUMBER OF SEXUALLY ACTIVE YOUTH WHO TALKED WITH AN ADULT SIGNIFICANTLY INCREASED, AS DID THEIR AWARENESS OF WHERE TO GET BIRTH CONTROL. THESE CHANGES IN TURN INCREASED THE USE OF BIRTH CONTROL, DECREASED THE RATE OF PREGNANCY AND STDs, AND INCREASED THE NUMBER OF YOUTH USING REPRODUCTIVE HEALTH SERVICES."

surprising outcome. Schools are flash points for a range of political issues, including sex education, and curriculum decisions are made at the district level, not the neighborhood. Although San Diego was able to use school facilities for community education workshops, the reality in all of the sites was that Plain Talk's core message of protecting sexually active youth was, in the words of P/PV evaluators, "too controversial to be included in formal public school curricula."

"Empirical Proof"

Initiatives like Plain Talk, which seek changes in an entire community, are notoriously difficult to evaluate. The most rigorous method of measuring the impact of a program or public policy is to create two statistically identical groups of community residents, only one of which is exposed to the intervention being evaluated. In general, differences in outcomes between the two groups can confidently be attributed to the initiative.

Because Plain Talk sought to influence an entire community's attitudes toward protecting sexually active youth, it was not possible to have a local comparison group of teens who did not receive the Plain Talk message. And although it is possible to select a comparison neighborhood with similar socioeconomic and demographic characteristics, virtually no communities remain sufficiently similar over a four-year period to allow reliable conclusions about an initiative's impact.

Plain Talk's approach to this evaluation challenge was to interview a random set of teens, ages 12 to 18, in 1994, and another randomly selected group of adolescents in 1998. In each survey, evaluators collected information about teens' knowledge of pregnancy, contraception, and STDs; their attitudes toward these topics; their communications with adults; and their use of reproductive health services and contraceptives. By adjusting for demographic shifts and employing other social science techniques, P/PV was able to construct a statistical comparison group and analyze causal links between Plain Talk and outcomes in the sites.

P/PV evaluators found strong quantitative links between responsible sexual behavior and sexually active youth who discussed pregnancy, contraception, or STDs with an adult. Compared with youth who did not have such conversations, the talkers were:

- more knowledgeable about birth control (+10 percent),
- more comfortable with condoms and birth control generally (+11 percent),
- more likely to be tested for STDs — an evaluation proxy for having a routine reproductive health check-up (+80 percent),
- less likely to create a pregnancy (-52 percent), and
- less likely be treated for — i.e., to have — an STD (-55 percent).

"Communication is important," says Jean Grossman, author of P/PV's outcomes analysis. "There wasn't empirical proof that that was the case. What I was able to do was show that the basic underlying theory of Plain Talk was valid."

Grossman and her colleagues also were able to make causal connections between neighborhood outcomes and specific site strategies. In Logan Heights and St. Thomas, two neighborhoods where community education focused on factual information, sexually active youth showed a

dramatic increase in their knowledge of birth control. Responding to a series of true-false questions about birth control, youth in Logan Heights averaged a 58 percent score for correct answers in 1994. Four years later, their average score was 71 percent. Equivalent gains were observed in St. Thomas. On the other hand, in Mechanicsville, where there was less emphasis on facts about sexuality and contraception and more emphasis on techniques of adult-youth communication, the scores for teens' knowledge of birth control were virtually the same in 1994 and 1998.

Although the Plain Talk evaluations have provided encouraging news about protecting sexually active youth, there is, in the words of researchers, "a sobering side" to the initiative's outcomes. In absolute terms, the positive changes in the Plain Talk neighborhoods were "modest." In St. Thomas, for example, a small and cohesive community where local youth likely had relatively long, sustained exposure to the Plain Talk message, only 65 percent of the neighborhood's sexually active youth had spoken to an adult in the last year and only 75 percent knew where to find contraceptives.

The Plain Talk outcomes study also reveals a paradox in Mechanicsville, the site with the smallest proportional exposure to the Plain Talk message, the largest drop in teen pregnancy rates, and the sharpest rise in STDs. Making sense of these outcomes raises a number of questions — for example, was the drop in teen pregnancy rates related to the Georgia Campaign for Adolescent Pregnancy Prevention, an initiative similar to Plain Talk that was also operating in the neighborhood? Did decreases in teen pregnancy and increases in STDs reflect a growing use of injectable contraceptives, which provide excellent protection against pregnancy and absolutely none against STDs?

Whatever the answers to these and other questions posed by the data from Plain Talk, there is one general P/PV conclusion about protecting sexually active teens that seems beyond dispute: "There is clearly more work to do."

"Committed to Change"

Some of the positive Plain Talk outcomes resist easy quantitative measurement. A "profound" aspect of the initiative, says Atlanta's Cheryl Boykins, was the evolution of residents' commitment to protecting sexually active youth to their interest in a broader range of neighborhood issues — for example, drugs, violence, and housing. "What happened was that people began to be eyewitnesses and experience some of the conditions of the households they would enter," says Boykins. "They took ownership, and they began to be more committed to change in the community."

Former teen mother Demetria Farve says she was deeply affected by her role as a Walker and Talker in New Orleans. "I came to realize that I needed to go back and get my GED and computer training." Currently employed as a clerical specialist, Farve has purchased a house across the street from the St. Thomas housing development. "I've made the choice to stay in my community and not just leave because I was able 'to better myself,'" she says. "I feel that the community and the leadership of it really invested a lot in me, and the least that I can do is stay here and be of some help."

PLAIN TALK RESOURCES

The Plain Talk reports listed below are available online at the publications page of the Annie E. Casey Foundation's website (www.aecf.org/publications/index.htm). Later this year Public/Private Ventures will publish a follow-up analysis of Plain Talk outcomes in Atlanta, New Orleans, and San Diego.

The Plain Talk Planning Year: Mobilizing Communities to Change, Lauren J. Kotloff, Phoebe A. Roaf, and Michelle Alberti Gambone, Public/Private Ventures, Spring 1995.

Plain Talk: Addressing Adolescent Sexuality Through a Community Initiative, Karen E. Walker and Lauren J. Kotloff, Public/Private Ventures, September 1999.

Plain Talk: The Story of a Community-Based Strategy to Reduce Teen Pregnancy, Population Services International, 1998.

Plain Talk Starter Kit: A Practical Guide to Community-Based Programming to Reduce Teen Pregnancy, STDs, and HIV/AIDS, Population Services International, 1999.

Resident Involvement in Community Change: The Experiences of Two Initiatives, Karen E. Walker, Bernardine H. Watson, and Linda Z. Jucovy, Public/Private Ventures, Summer 1999, is available at www.ppv.org.

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